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ACCR Updates

Melissa Riddle, CTR

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- **Abby Holt** – Director
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- **Yen Egbe** – Epidemiologist
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- **Mary Beth Lisko** – CIMS
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- **Alicia Bell** – Admin Analysist
- Vacant – Education/Training Coordinator

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2014 Data

NAACCR Gold!!!!

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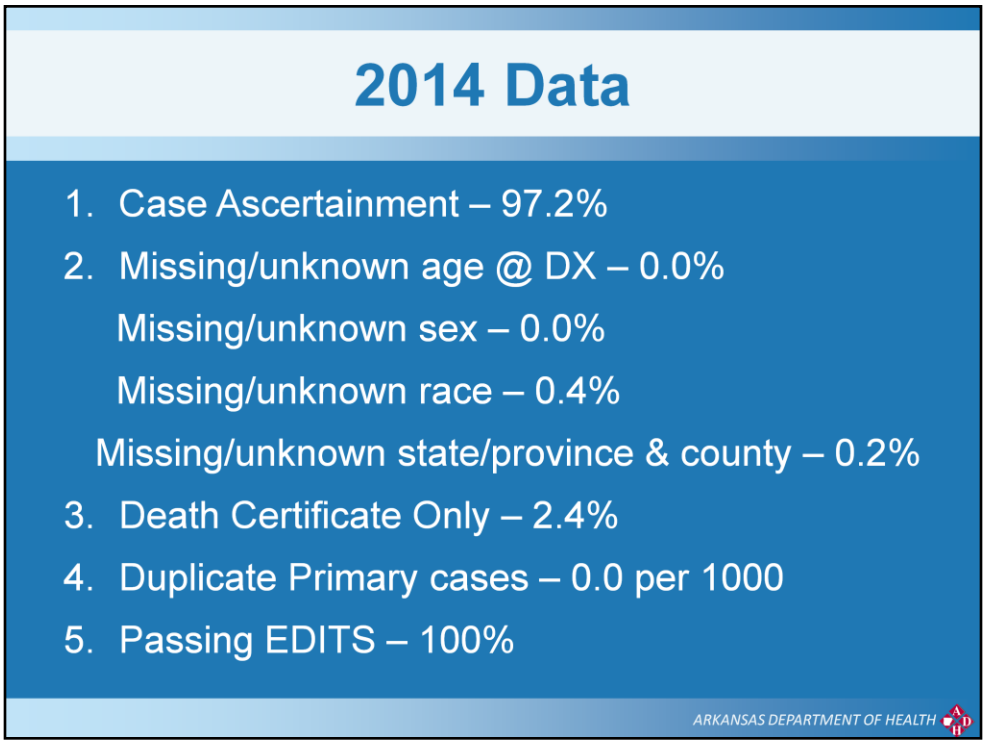
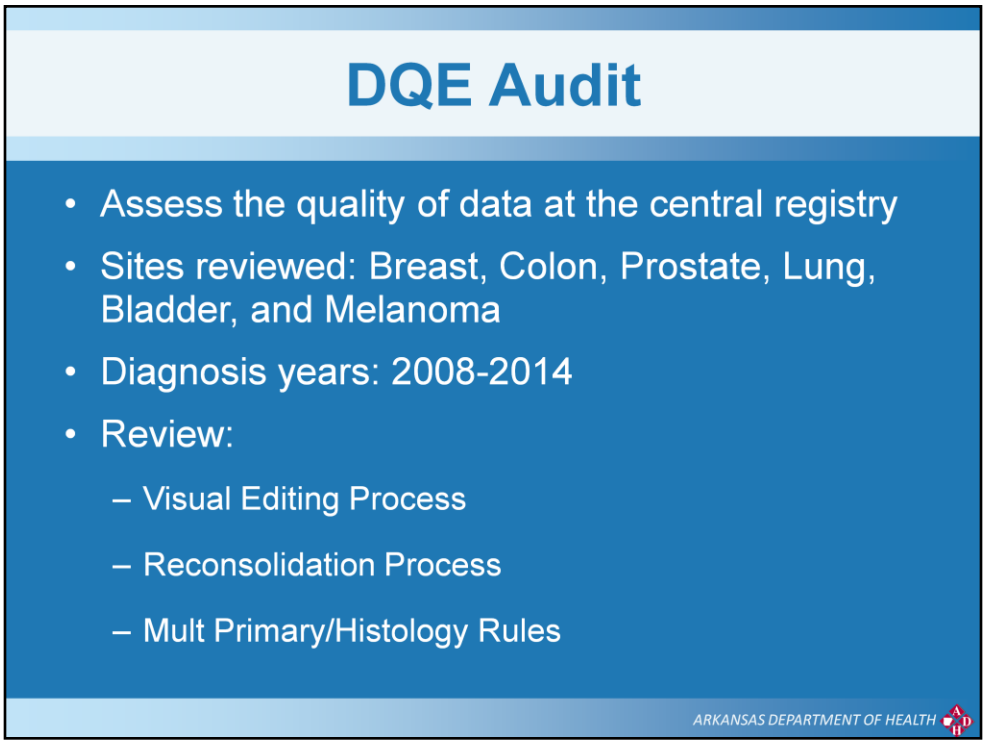
2015 case ascertainment numbers are looking good.

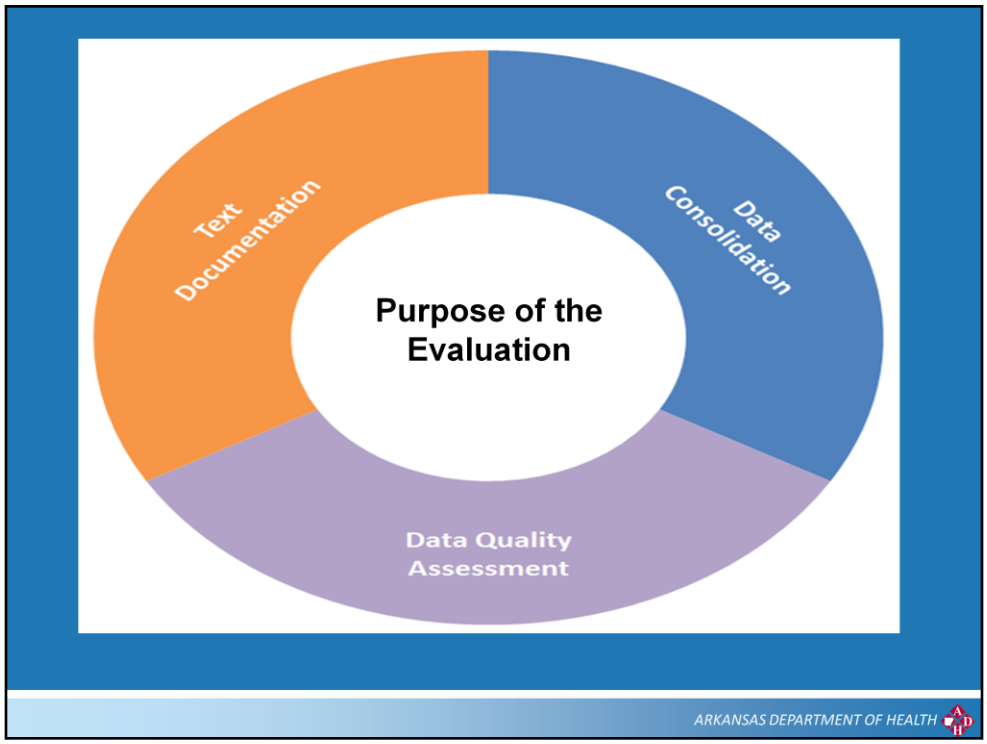


Case Ascertainment - 2015 data is looking really good but we need to strive to get the 2016 data completed and submitted in a timely manner currently showing only 60% of cases expected have been submitted for 2016. This means a lot of our facilities are delinquent in reporting.

Death Certificate Only – these are cases that were found on death certificates only, no other information available

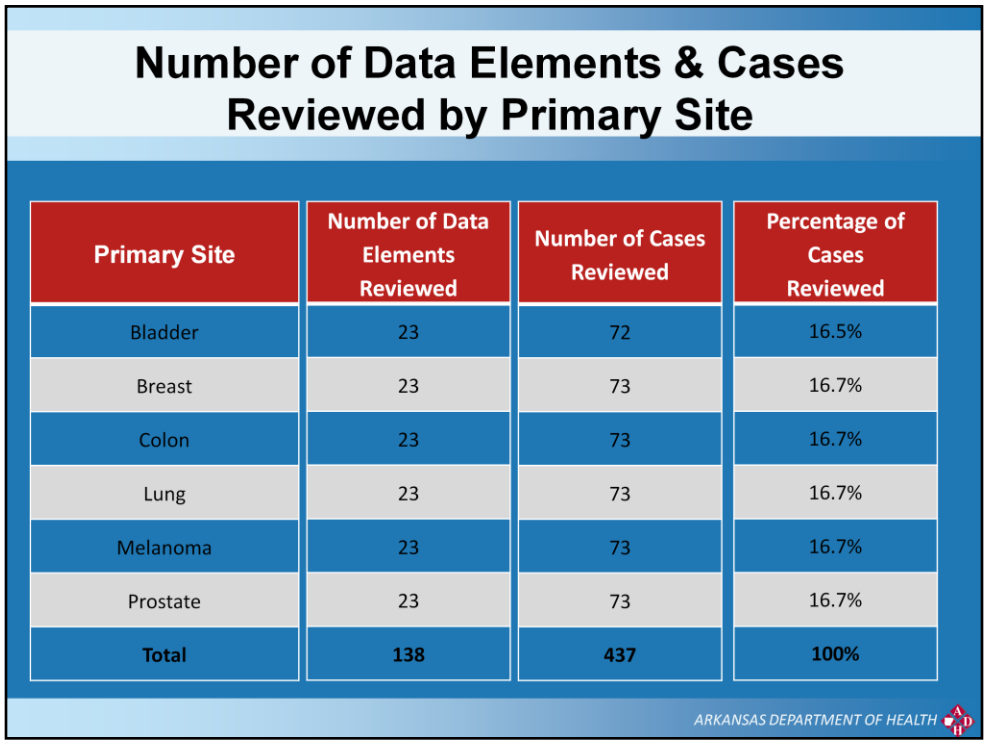


NPCR – performed a DQE (Data Quality Eval) audit on the AR Central Cancer Registry. This focused on the years 2008-2014 for the sites breast, colon, prostate, lung, bladder and melanoma cases to ensure that we were performing adequate visual editing, our reconsolidation (tumor deduplication aka merging) process that we follow, and if these complied with the MP/H Rules.

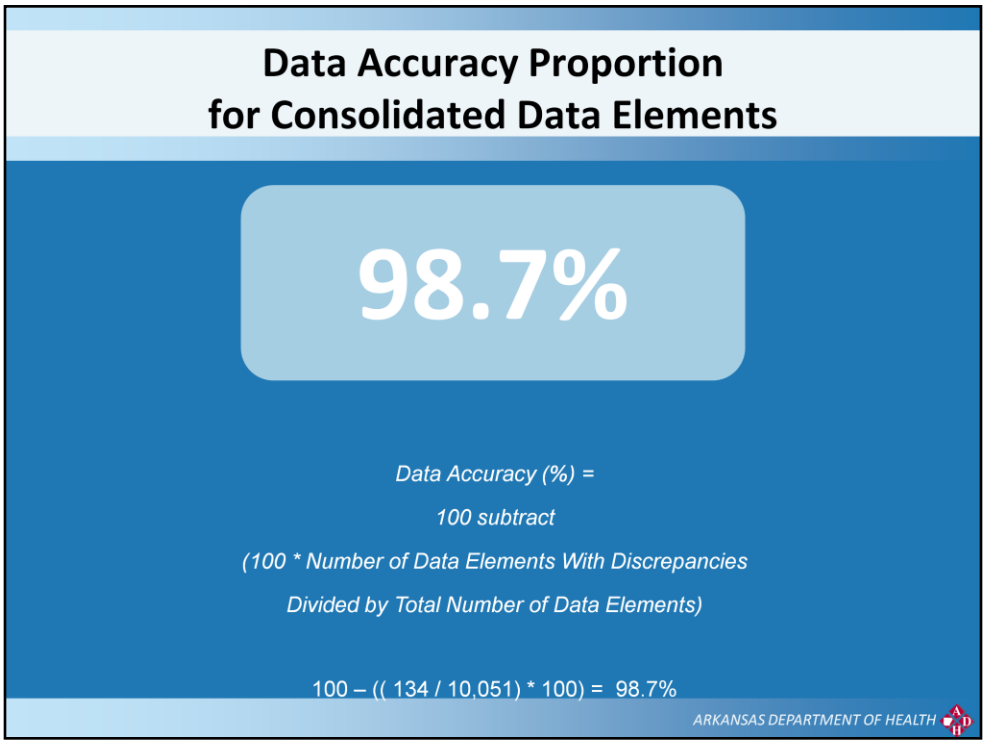


The data quality evaluations are conducted as part of the NPCR program which requires any state that has received NPCR funding from the CDC to undergo a data quality evaluation once every 5 years by a CDC approved organization.

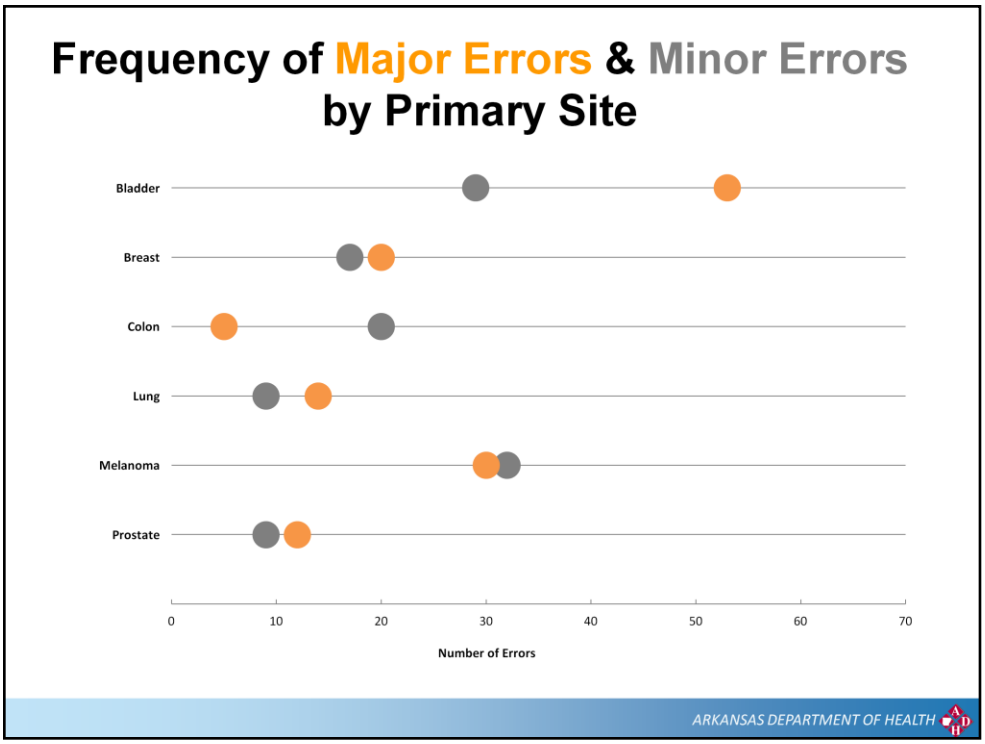
The purpose of the evaluation is to assess the data quality within the ACCR**.** The quality of the data collected and reported by central cancer registries depends on completeness of reporting, practices in place at the ACCR level regarding data quality editing and record consolidation and adherence to national program standards – for example – text documentation is a NPCR required data element. The assessment also included reviewing a sample of multiple primary tumors to determine adherence to the Multiple Primary and Histology rules.



This table shows the total number of data elements and the total number and percentage of cases evaluated for each cancer site.

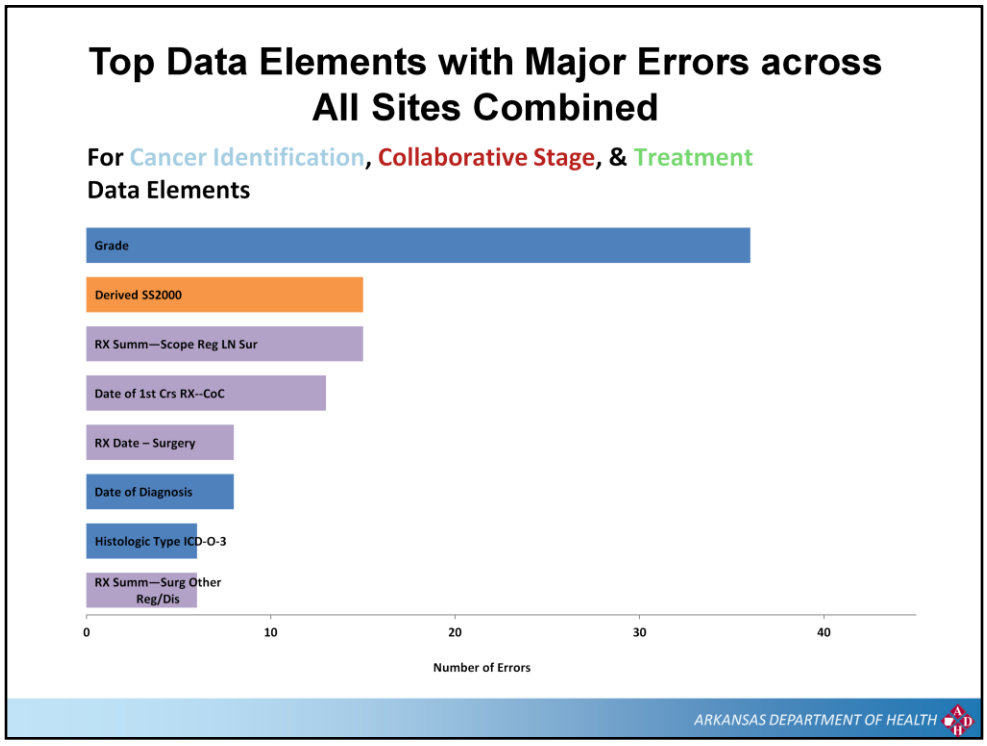


A total of 437 cases were reconsolidated. Of a total of 10,051 possible data elements that could have had errors, 1.3 percent were found to have major errors (134 errors). The resultant aggregate data accuracy rate for the ACCR was 98.7 percent.



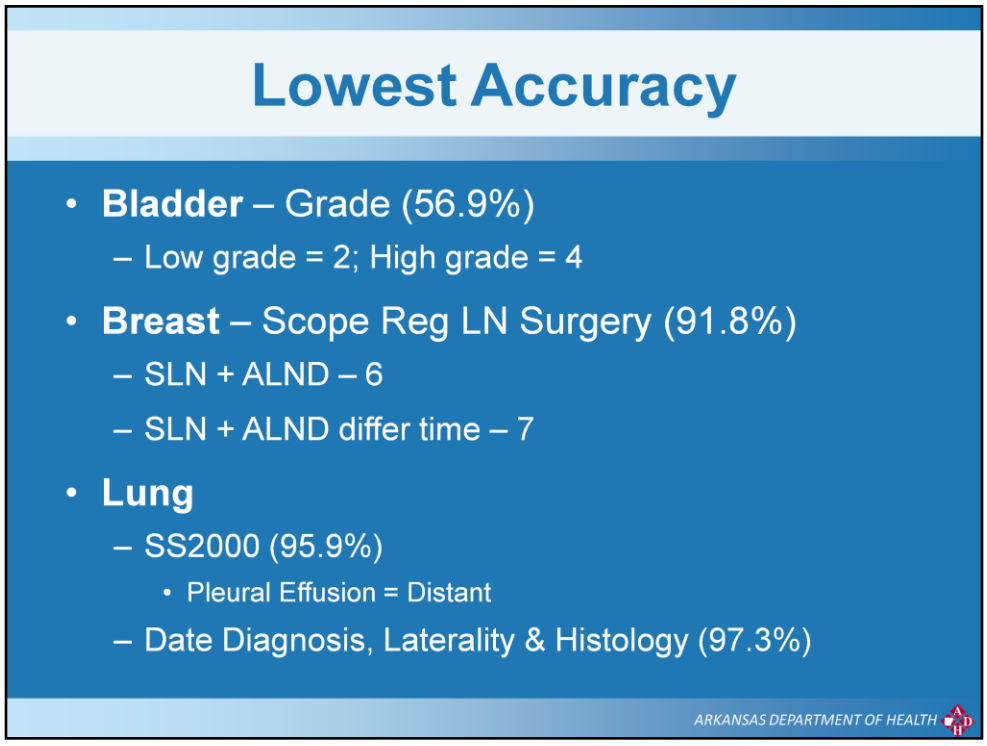
When broken down by primary site, bladder cases contributed the most errors (53 major errors). Colon cases contained the fewest major errors (5).

Additionally, minor error counts were calculated but not included in the overall accuracy proportion. There were 116 minor errors across primary sites with melanoma and bladder cases contributing the most minor errors. When combined with major errors, the total error count is 250 which translates to a 97.5% overall accuracy rate.



Looking at individual data elements, Grade contained the most major errors, followed Derived SS2000 and Scope Regional Lymph Node Surgery.

Grade alone contributed 36 major errors.

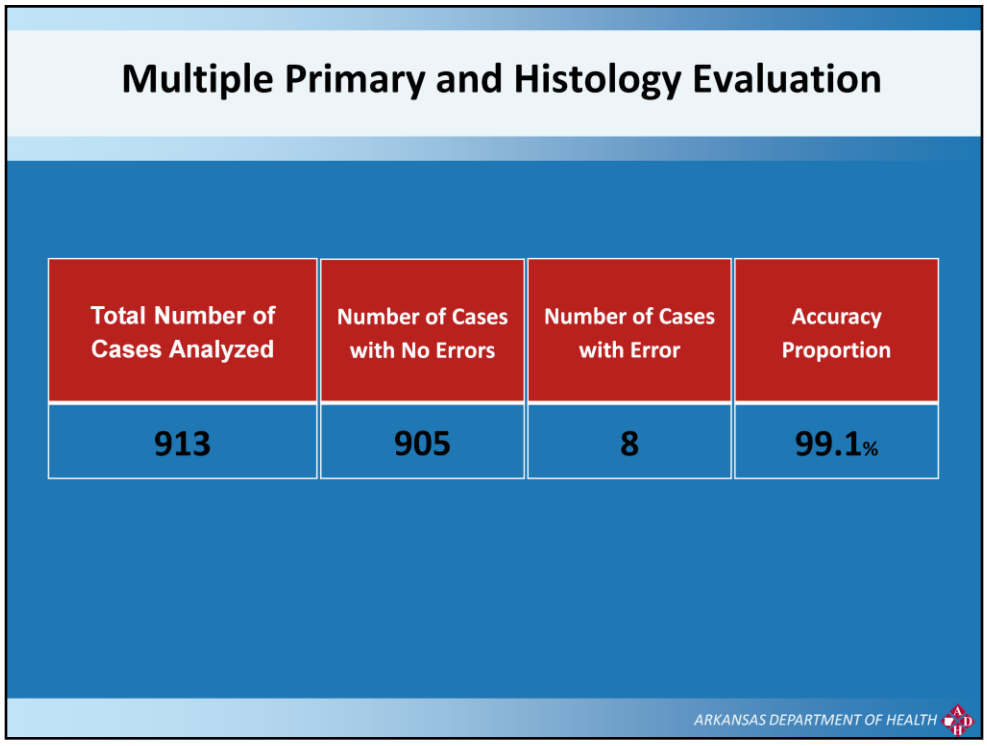


Bladder had the lowest accuracy rate at 56.9%. Major errors were in coding low and high grade tumors. Following the SEER 2014 Rules and FORDS 2016 low grade = 2 and high grade = 4. If the pathology text indicates grade 2/3, then use the 3 grade system.

Breast had lowest accuracy rate at 91.8% for scope of regional LN surgery because of missed SLN biopsy not coded. Along with SLN + ALND same or different times

Lowest Accuracy

- **Melanoma**
  - SS2000 (91.8%)
    - Code unknown – Text indicate localized
  - Date First Course Treatment, Date Primary Site Surgery, and Scope of Reg LN Surgery (94.5%)
    - Incisional biopsy rarely performed and need to clarified in text if first biopsy is incisional vs. excisional
    - Difference in excisional biopsy as treatment vs. SDSP
    - SLN biopsy missed
- **Prostate** – Date First Course Treatment (94.5%)
  - Active surveillance not recorded as treatment



In accordance with the Multiple Primary and Histology Rules, Westat evaluated a sample of consolidated records to determine any discrepancies in the application of the rules during consolidation practices. In these cases, each primary tumor was reviewed and a determination as to whether the rules were applied correctly was made. The review consisted of 913 consolidated records with more than one primary tumor. Of those 913 cases, only 8 records were found to be discrepant resulting in a 99.1% accuracy rate.

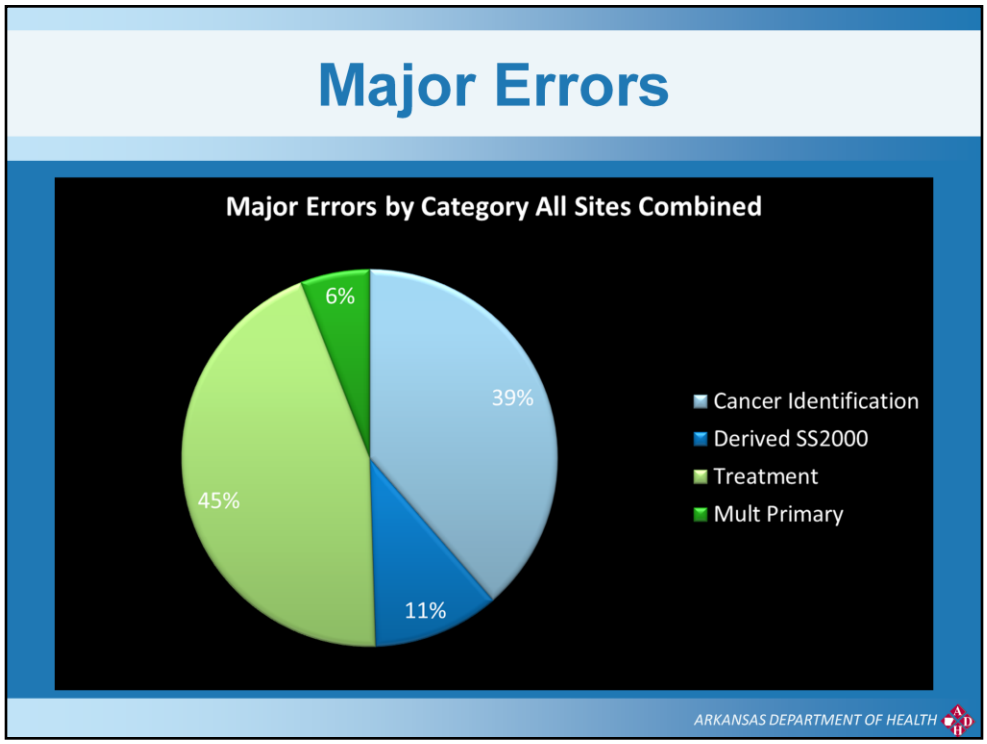
The ACCR should be commended for this result.

MP/H Evaluation

- **Lung –**
  - Miscoded laterality made new primary
    - Biopsy inaccurately labeled RUL and should have been LUL, this was not a new primary
  - Miscoded 2nd Primary
    - Text states developing RUL c/w second malignancy (not abstracted)
  - Metastatic Site coded as 2nd primary
    - Metastatic disease developed later and abstracted as a new case
- **Colon** – 0 errors

MP/H Evaluation

- **Bladder**
  - Initial biopsy TCC in situ, less than 60 days Radical Cystoprostatectomy reveals TCC in situ – coded multiple, should be single M6
- **Breast**
  - Histology: Infiltrating ductal carcinoma w/ neuroendocrine features, 8574/3 per SINQ20160074
- **Melanoma**
  - Primary site and laterality not updated based on text
  - Metastasis coded as 2nd primary

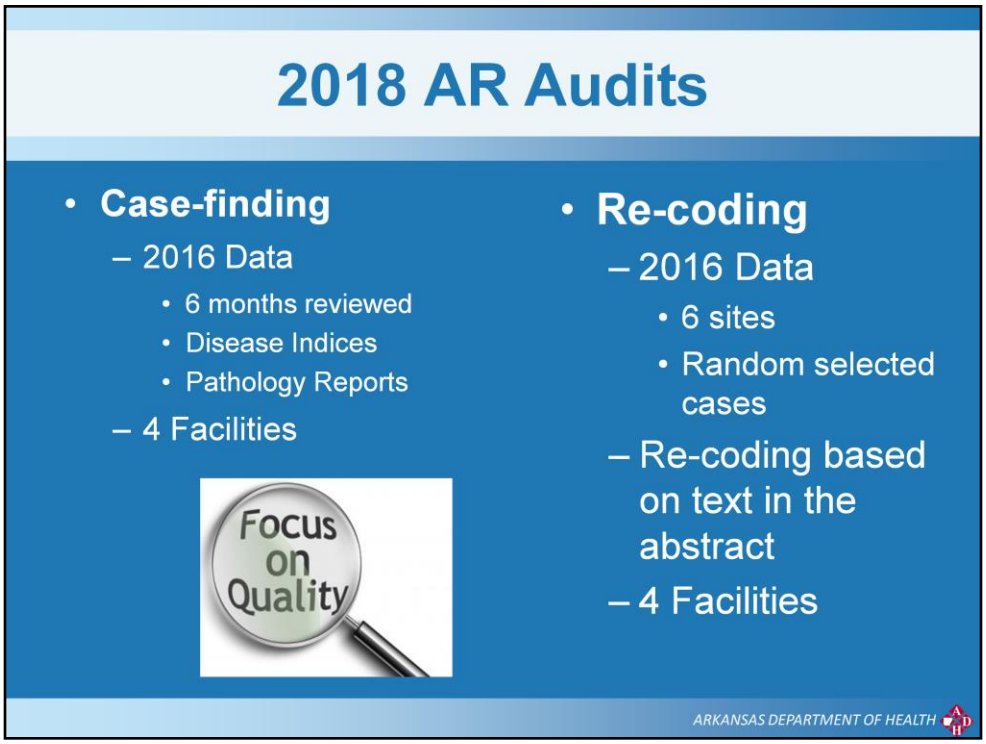


45% of all major errors are concentrated in treatment data elements. 39% were in cancer identification data elements (grade, laterality, date diagnosis, etc.). Derived SS2000 had 11% of the major errors while Multiple Primary only had 6%.

This year we contracted our audits out with Registry Partners and they performed 3 case-finding audits and 3 re-abstracting audits. These audits reviewed 2015 data.

The casefinding audit focused on 5months of data using disease indices and pathology reports to see if there were any possible missed cases.

The re-abstracting audit reviewed 5 sites and random cases were chosen for the review. The auditors re-abstracted the case based on the information located within the facility's medical record. This helps to locate any areas where further training may be necessary.



Next year we plan to contract out the audits again. We will be performing Case-finding and Re-coding audits on 2016 data.

For case-finding we will review 6mo worth of data from disease indices and pathology reports on 4 facilities.

For the re-coding audit there will 6 sites reviewed and randomly selected cases from 4 facilities. This re-code will be based upon the text that was submitted by the reporting facility. The auditor will abstract the case based solely on the text provided.

Which leads me to my next topic….text

Text Me….

- Text is vital to an abstract
- Changes made to an abstract are based on text
- It is the only way to validate your codes
- Lack of text impacted the following treatment items:
  - Hormone
  - Immunotherapy
  - Transplant/Endocrine Therapy

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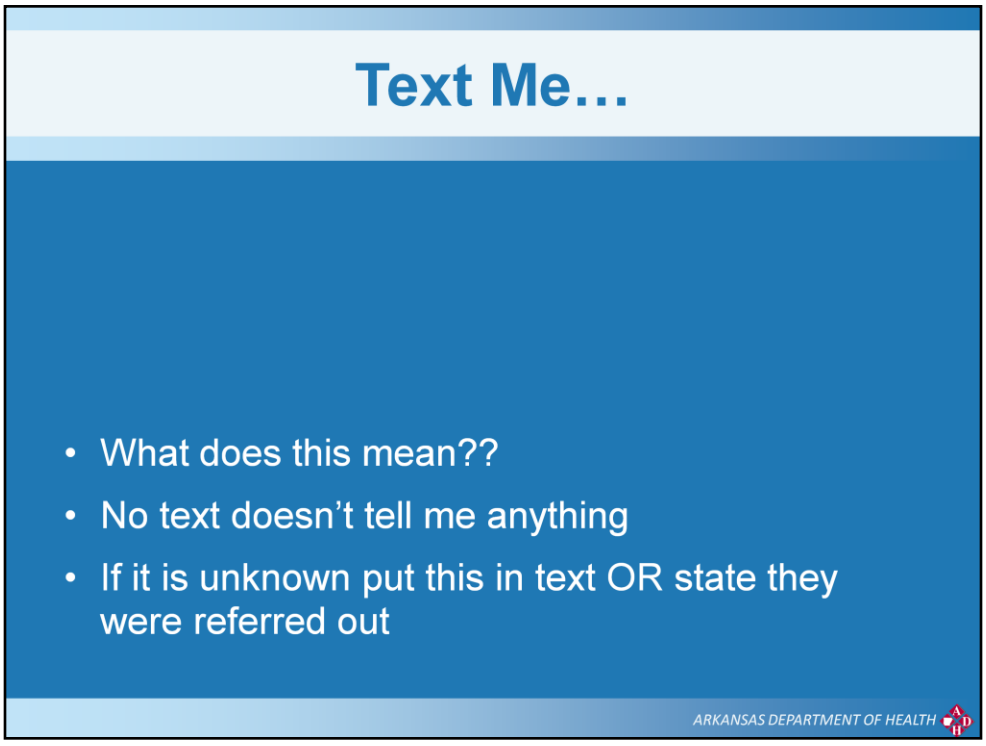
Accurate and complete text is vital to an abstract. When we make a change or have to decide between codes we use the one that has the text to back it up. Your text validates the code you chose.

In the DQE audit the lack of text impacted treatment data items.



Blank….no text….

click what does this mean? No text…does it mean unknown or none

If you don't know or is unavailable please include this in the text fields.

What do you want in text fields? How much information?

Please only give me what is important to their cancer diagnosis. I don't need information about a tonsillectomy performed when they were 3yr old or an appendectomy at 12. Keep it concise and to the point. Ask yourself will the information I include in text help them to understand this case and why I coded what I did?

Be sure to always include dates, type of imaging/procedures/treatments and the pertinent findings on each. The pathology text field should include the date, pathology number, and the findings on the pathology report. Your staging text field should give us the physician's staging and/or the information that backs up the stage in the staging data items.

Text Example - 1

5/6/16-49YO, WF PRESENTED TO PCP FOR HERNIA & LLQ PAIN. INCIDENTAL FNDING OF RCC. HERE FOR SX. NO TOB/ DZETOH. FH: NEG

2/23/16-CT A/P: RENAL MASS, ENLRGING RT UPPERPOLE RENAL MASS, MOST CONSISTNT W/SOLID RENAL MASS, RCC IS OF CONCERN. NO LN SEEN OR METS

5/6/16-KIDNEY, RT, LAP PARTIAL ROBOTIC RETROPERITO NEPH. RT UPPER POST POLE RENAL MASS. ALL TUMOR REMOVED.

5/6/16- Path: RT KIDNEY, PARTIAL NEPH, RCC, 2.2 CM, UNIFOCAL, TUMOR LIMITED TO KIDNEY, CLEAR CELL CA, GR 2, MARG CLEAR, LVI NEG, REG LN NOT SAMPLED. PT1A, PNX.

- **Date DX** – 2016/03/29
- **Path Staging**:
  - pT1a
  - cN0
  - cM0
  - Group 1
- **Clinical Staging**:
  - cT1a
  - cN0
  - cM0
  - Group 1
- **Date 1st Course TX** – 2016/05/06

Text Example - 2

68 YOWF, NON HISPANIC, MARRIED, METHODIST, UNK PLACE OF BIRTH, PCP DR. _____, PT W/A HX OF GSW TO RT CHEST AS A CHILD, PT NOW W/A LT HILAR MASS W/ENLARGED LT ADRENAL NODE & MEDISTINAL NODES CONCERNING FOR MALIGNANCY FOUND DURING WORKUP OFR PNEUMONIA ALSO NOTED ARE RETAINED FOREIGN BODIES ON CT WORKUP. PT WAS SEEN IN SURGICAL ONC ON 5/9/16, RECOMMENDATION IS FOR FNA OF LNS & ADRENAL GLANDS TO DETERMINE HISTOLOGY & DIRECT TX PLAN. RECOMMENDATION WAS FOR NEOADJUVANT CHEMO, PT WANTED HER TX CLOSER TO HOME, & BEGAN CHEMO W/DR. _____LATE 5/2016. PT RECEIVED 3 CYCLES BEFORE EXPIRING ON 8/5/16. PT IS (+) SMOKING, (+) ALCOHOL, (+) FOR BOTH PARENTS W/LUNG CA, SISTER W/ UTERINE, VAGINAL & OVARIAN CA, PATERNAL AUNT W/BREAST CA, & MATERNAL GRANDFATHER W/LUNG CA, PT IS 132 LBS & 64 INCHES TALL.

4/29/16-O/S CT CHEST-CHANGES MOST COMPATIBLE W/LT HILAR CENTRAL BRONCHOGENIC MALIGNANCY W/POST OBSTRUCTIVE PNEUMONITIS IN THE UPPER LOBE & LOWER LOBE. THIS MASS (4 X 5.6CM) ENCASES THE UPPER LOBE & LOWER LOBE BRONCHI, NARROWING THE BRONCHI. MULTIPLE NONCALCIFIED NODUELS ARE PRESENT THROUGHOUT BOTH LUNG COMPATIBLE W/METS DZ. THERE IS A NODULE IN LT ADRENAL GLAND WHICH IS PROBABLY METS AS WELL. ENLARGED MEDIASTINAL LNS ARE PRESENT COMPAT/W METS DZ. SMALL LT PLEURAL EFFUSION WHICH IS NONSPECIFIC, BUT COULD BE MALIGNANT, OR PARAPNEUMONIC EFFUSION RELATED TO INFECTION. EMPHYEMA; 5/18/16-O/S PET IS NOT AVAILABLE FOR REVIEW; 7/13/1-O/S CT CHEST-HETEROGENEOUS LLL IN FILTRATE IN THIS PT W/A NON SMALL CELL LUNG CA. APPEARANCE IS VERY SIMILAR TO PRIOR CT DATED 4/29/15. FINDINGS MAY REFLECT MALIGNANCY W/POST OBSTRUCTIVE PNEURMONIA WHIHC MAY BE ACUTE OR CHRONIC

5/10/16-FNA 4L LN & ADRENAL GLAND @ _____

Text Example - 2

5/10/16-BRONCHOSCOPY + FNA OF L4 LN & ADRENAL GLAND-THE PATIENT WAS BROUGHT TO THE PROCEDURE ROOM AND SEDATED. THE ORAL CAVITY WAS ENTERED FIRMLY AND THE ESOPHAGUS WAS ENTERED. THE SCOPE WAS PASSED DOWN INTO THE SUBDIAPHRAGMATIC REGION, AND AN AREA OF ADRENAL ENLARGEMENT JUST BELOW THE DIAPHRAGM COULD BE VISUALIZED. FNA SAMPLES WERE OBTAINED. THE SCOPE WAS THEN PULLED BACK. THERE WERE ENLARGED NODES AT BOTH STATIONS 7 AND 4L. WE SAMPLED 4L. THIS WAS POSITIVE ON-SITE AND WHEN AN ADEQUATE SAMPLE HAD BEEN OBTAINED, THE PROCEDURE WAS TERMINATED.

5/10/16- Path, (A) FNA 4L LN (+) FOR MALIGNANT CELLS-MALIGNANT CELLS ARE REACTIVE TO TTF-1 AND NON-REACTIVE TO P63 WITH APPROPRIATE CONTROLS. THIS IMMUNOHISTOCHEMICAL PROFILE IS CONSISTENT WITH METASTATIC PULMONARY ADENOCARCINOMA. (B) FNA ADRENAL (-) FOR MALIGNANT CELLS.

CT2B (4 X 5.6 CM CENTRAL MASS), CN2 (AP WINDOW LN MEA 1.9 X 1.1 CM, SUBCARINAL LN MEA 1.8 X 1.6CM), CM0 STAGE 3A

- **Date DX**: 2016/04/29
- **Pathologic Staging**:
  - pT blank
  - pN2
  - cM0
  - Group 3A
- **Clinical Staging**:
  - cT blank
  - cN2
  - cM0
  - Group 3A
- **Date 1st Course TX**: 2016/05
- **Scope Reg LN Surg**: 0
- **SDSP**: 01 **Date**: 2016/05/10

BEWARE!!!
Don’t get tripped up…

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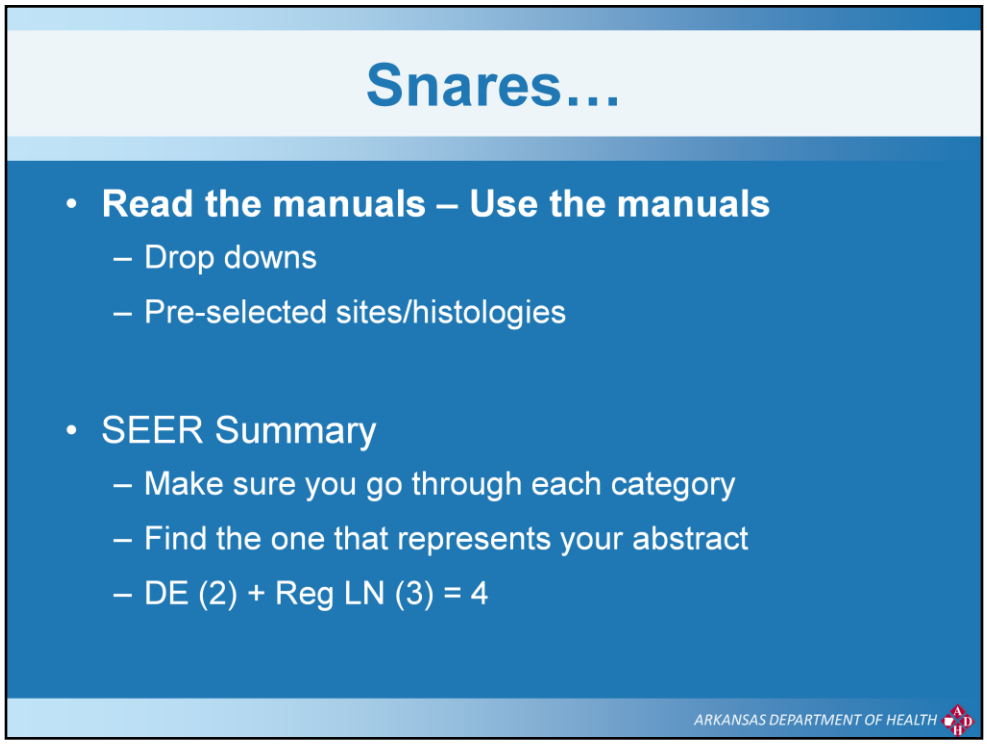

Read the manuals – Use the manuals….repeat with me….

Many of the errors we make and come across is due to not reading and/or using the manuals

We are lazy!!! We want to just pick from a drop down box and go. It isn't that simple. You really must and should use your manuals no matter how long you have been abstracting.

Watch out for those pre-selected sites and histologies if your software uploads your disease indices and/or pathology reports into your registry software. These codes may not always be the most specific and may be incorrect.

SEER Summary – here is a perfect example of using the manual. Many of SS errors I see are because the manual was not used. We just do our best 'guess' and choose a code from the drop down menu. You have to go through each category and look at what is listed, once you find the one that represents the case use that code. Watch out for the DE + Reg LN combo – code 4, not just 3.

Snares…

- **Tumor Size Summary**
  - FORDS 2016, e-p. 159-161
  - REQUIRED item for 2016 + cases
- **Mets @ DX** – bone/brain/distant LN/liver/lung/other
  - FORDS 2016, e-p. 162-173
  - REQUIRED items for 2016 + cases

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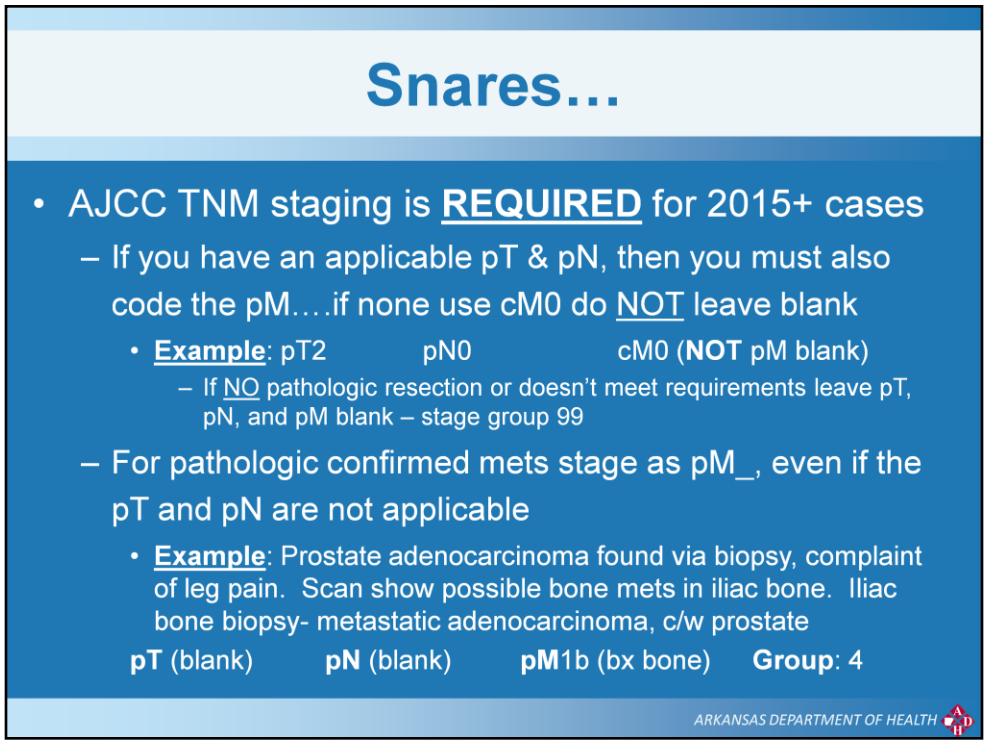
Tumor Size Summary is required for 2016 cases and forward. Please use the instructions as found in the FORDS manual.

Mets at DX sites is also required for 2016 cases and forward. Please use the instructions as found in the FORDS manual.



Follow the rules/guidelines per the applicable TNM manual based upon diagnosis year.

Stage the case according to the classification rules within each chapter and general guidelines.

Please keep in mind that if you have an applicable pT and pN (typically resection of the primary site and regional LN) then you still must code the pM data field – do not leave it blank. If there is no metastatic disease clinically then record the pM as a cM0.

If there is no pathologic resection, doesn't meet the classification requirements, or it is unknown if a resection is performed code the pathologic T, N, M as blank and group as 99.

When there is pathologic confirmed mets you can stage the case pathologically based on the pM alone. Record the pM status even if the pT and pN are not applicable.

Example:

1/2017 Patient with prostate adenocarcinoma found via biopsy for elevated PSA. He also complains of leg pain and a bone scan is carried out revealing a possible bone metastasis. 2/2017The patient then undergoes a bone biopsy which reveals metastatic adenoca c/w prostate primary. There is no prostatectomy performed.

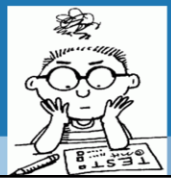
Record the staging as pT blank pN blank pM1b group 4

POP QUIZ

56yo AAF with palpable breast mass, abnormal mammogram. Here for breast biopsy

Reporting facility – R Breast biopsy on 2/15/16 revealing infiltrating ductal carcinoma, BR Score 7, ER/PR +, HER2 1+ Neg

No other information



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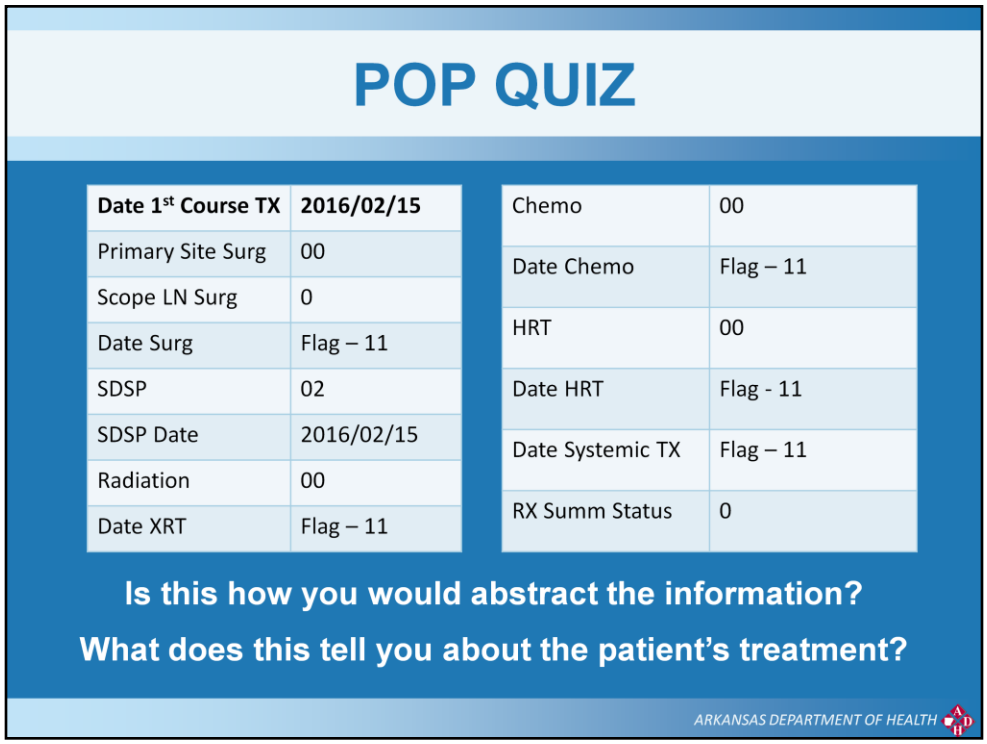
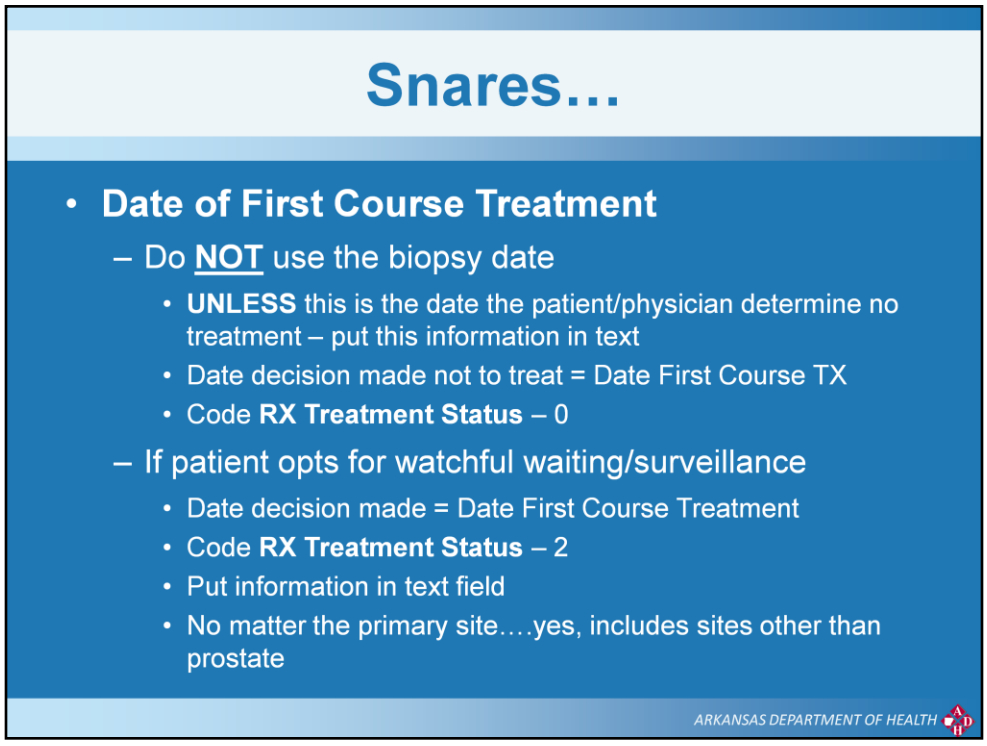


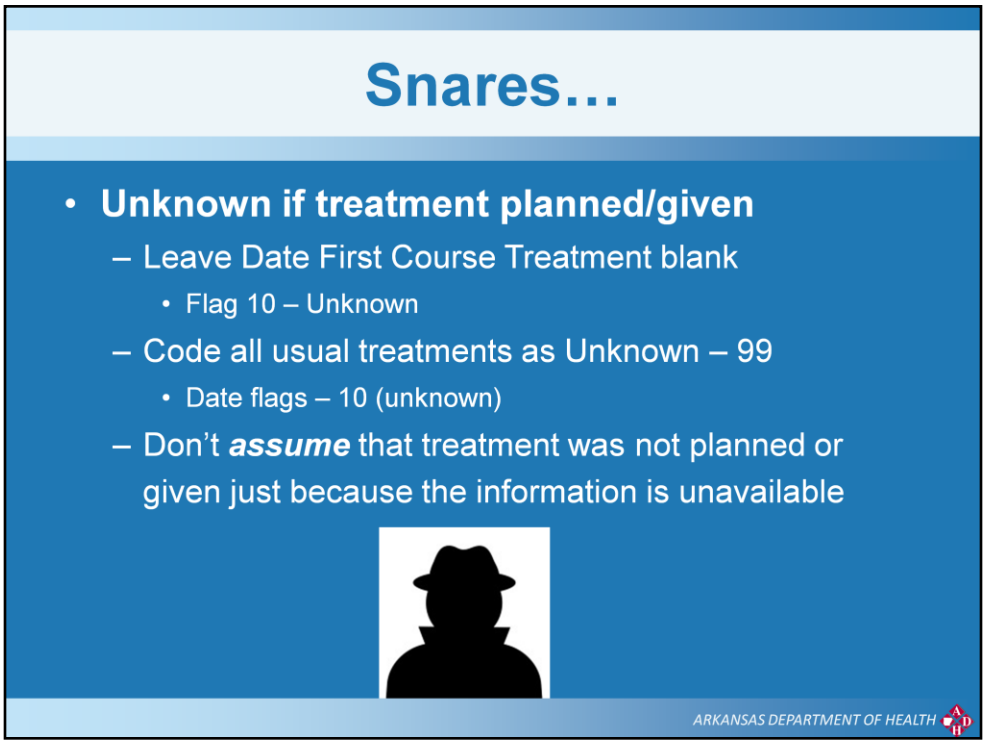
If you code the biopsy date as the date of first course treatment and all other treatment fields are none and your RX Summ Status is 0 – none then you are saying this patient did not receive any treatment. Is that what was in your chart OR do you just not have the treatment information? These are two different things and must be reflected in your abstract.



Do NOT use the biopsy date as first course treatment UNLESS this is the date that it was determined no treatment was to be performed/planned. Make sure this is backed up in your text.

When a decision is made not to treat (this is different from active surveillance or watchful wait) code the RX Treatment status summary field as 0 (no treatment).

If the patient opts for watchful waiting/active surveillance then the date this was chosen is date of first course treatment and the RX Treatment Status Summ is code 2, and be sure to put this decision with the date in text. It doesn't matter the primary site – more than just prostate cancer can chose watchful wait (CLL, meningioma)



If you don't know, then you don't know. This should be reflected in your abstract.

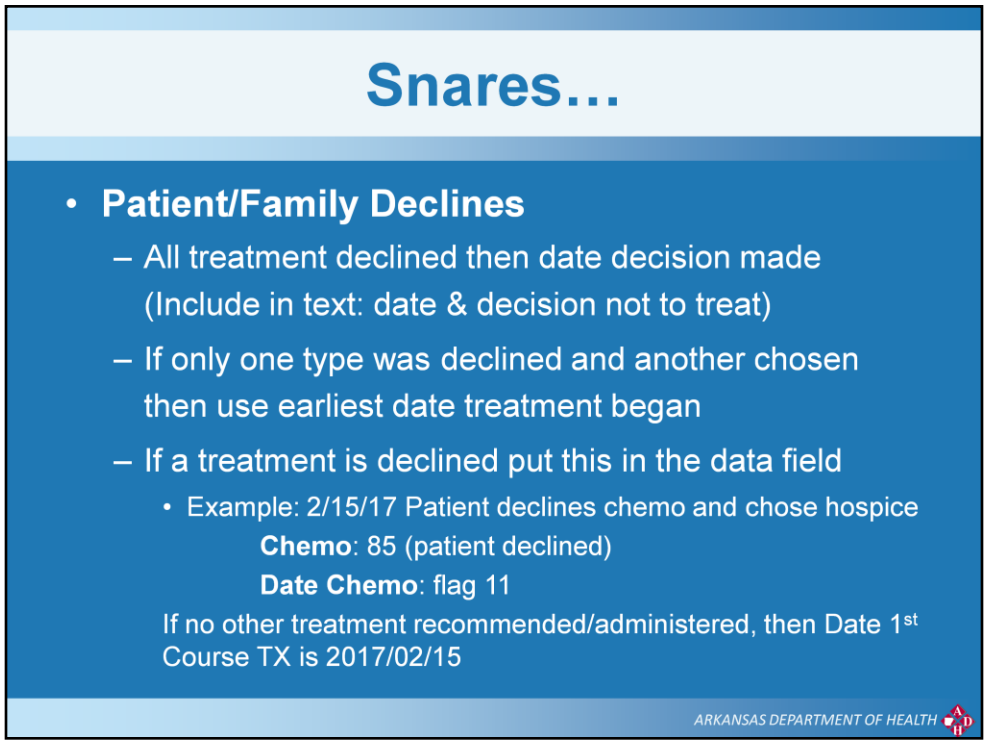
So, they come to your hospital and only have a biopsy or scan that diagnoses their cancer, but you don't know anything else. They disappear…Poof, Gone!

Then your date of first course treatment is blank and the flag is 10 – unknown. Why?! Because you don't know.

Depending upon the site, histology, stage determine the usual treatments performed and code those as unknown (99) and date flags as 10.

If you have a breast case where the biopsy reveals invasive ductal carcinoma with ER/PR +, HER2 neg, and nothing else and scans show limited clinical stage disease. Then you would code surgery, radiation, hormone to 99 as those are usual treatments for breast cases where there is low stage and ER/PR positive.

Don't assume (you know what that does) the treatment was not planned or given just because it isn't in your records.



When a patient and/or family declines the recommended treatment there are a few things to consider.

Was all the planned or recommended treatment declined? Was it just one or two treatment options declined and another chosen?

If all the treatment is declined the date of this decision made by the patient/family is used as date 1st course treatment. Be sure to include the information in text.

If only one type is declined and another treatment chosen record the date of the first treatment administered as date of 1st course treatment.

Ensure that your codes match your text. If a particular treatment was declined then code this using the appropriate 'patient/family declined' code for that data item. Don't just use code 00 – this means it wasn't even a recommendation or planned.

Case Scenario

35yo white male with leg pain for 1yr and incidental finding large mediastinal mass on CXR

1/15/17 CT C/A/P: Enlarged lymph nodes in mediastinum, retroperitoneum, and inguinal areas all suspicious for lymphoma

1/23/17 Inguinal LN biopsy: Diffuse large B cell lymphoma

No more information…..

Treatment codes???

Case Answer

SDSP	02
SDSP Date	2017/01/23
Date 1st Course TX	Flag – 10
Surgery Primary	00
Scope LN Surg	9
Date Surg	Flag – 11
Chemo	99
Date Chemo	Flag – 10
Systemic Date	Flag – 10
RX Summ Status	9

Snares…

- **Regional LN Surgery**
  - If there is a biopsy or FNA of a regional LN
    - Reg LN Pos: 00 (if neg) or 95 (if positive)
    - Reg LN Exam: 95
    - Scope of Regional LN Surg: 1
  - Positive biopsy/FNA but regional LND negative
    - Reg LN Pos: 95
    - Reg LN Exam: # examined on LND path report
    - Scope of Regional LN Surg: depend on # removed
  - SLN biopsy…..don't forget it!!!
    - 2, 6, or 7 are the appropriate codes for Scope LN Surg

Case Scenario

60yo with chronic cough and weight loss.

3/4/17 CXR – abnormal mass in RUL

3/10/17 CT Chest – 1.3cm mass RUL suspicious for carcinoma, some hilar and mediastinal LAD

3/20/17 Bronchoscopy w/ Mediastinoscopy: some abnormal mucosa in RUL, biopsy; enlarged 7R LN biopsy

3/20/17 RUL biopsy: Adenocarcinoma, MD; 7R LN biopsy- positive for met adenocarcinoma c/w lung

No More Information

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Case Answers

Date DX	2017/03/10
Reg LN Pos	95
Reg LN Exam	95
SDSP	02
Date SDSP	2017/03/20
Date 1st Course TX	2017/03/20
Primary Site Surg	99
Scope Reg LN Surg	1

Date 1st Surgery	2017/03/20
Most Defin Surg	Flag – 10
Radiation	99
Date XRT	Flag – 10
Chemo	99
Date Chemo	Flag – 10
RX Summ Status	1

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Remember to code/abstract what you know. If it isn't available and there is absolutely no information and you can't contact the physician then code as unknown if it is usual treatment.

Case Scenario

41yo with left breast abnormal mammogram and US with enlarged left axillary LN.

5/16/17 Core biopsy L breast: IDC, BR 6; L axillary LN FNA: metastatic breast cancer

6/1/17 L breast lumpectomy with L SLN biopsy and axillary LND

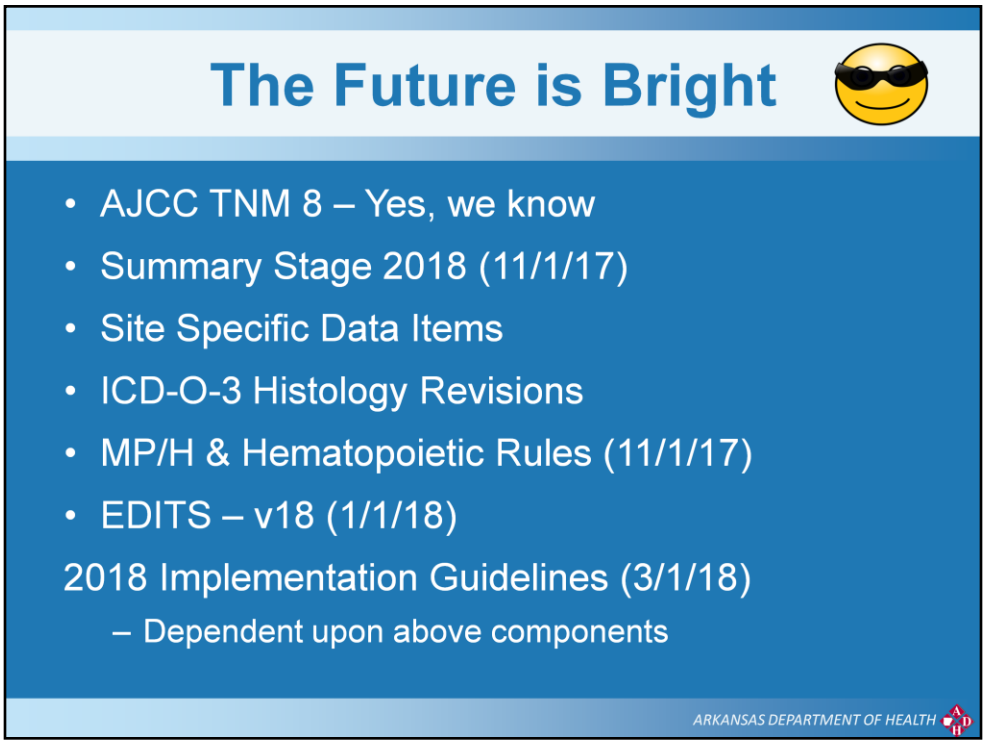
6/2/17 L lumpectomy: 2cm IDC, BR 6; 0/2 L SLN; 0/4 L axillary LN

No other information

Case Answers

Date DX	2017/05/16
Reg LN Pos	95
Reg LN Exam	06
SDSP	02
Date SDSP	2017/05/16
Date 1st Course TX	2017/05/16
Primary Site Surg	22
Scope Reg LN Surg	6

Date 1st Surgery	2016/05/16
Most Defin Surg	2016/06/01
Radiation	99
Date XRT	Flag – 10
Chemo	99
Date Chemo	Flag – 10
HRT	99
Date HRT	Flag – 10
RX Summ Status	1



Just a few reminders about what is coming….it is so much more than AJCC TNM 8. We will do our best to get training to everyone. Please try to attend the NAACCR webinars that we offer monthly. If you can't attend the live session please contact me to get the recording.

I am working on some recorded training sessions that will hopefully be ready by spring 2018 on our website for you all.

Thank you!!!

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ARKANSAS DEPARTMENT OF HEALTH